

MPECS August 2007 PRODUCTIVE PROVIDER Newsletter

By Jim Meeks, PA-C

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MARK YOUR CALENDARS

EVALUATION and MANAGEMENT CODING ESSENTIALS WORKSHOPS & LECTURES:

Jim Meeks, PA-C is dedicated to making your practice of medicine more productive, more profitable and ultimately more enjoyable. The comprehensive MPECS 4-hour **E/M CODING ESSENTIALS** workshop focuses on exactly what you need to know, the specifics of documentation and coding. If you ever find yourself questioning which E/M code you should use, you need this workshop!

MPECS workshops and lectures are now being scheduled;

UP-COMING MPECS WORKSHOPS;

Lehi, Utah

September 15, 2007

Las Vegas, Nevada

November 3, 2007

Orlando, Florida

March 14, 2008

See the **EVENTS** page on the **MPECS** web site for details and registration information.

CONFERENCE LECTURES;

AFPPA Conf. Las Vegas, NV

October 31, 2007

Available for 2007 - 2008 bookings. Contact me at PracticeProfitability@mpecs.org

Do I need to audit my charts?

Occasionally, I encounter a clinic or provider that never audits charts. At times, I am asked why auditing is even necessary. "Our billing and coding clerk has years of experience, I'm not worried" I've been told. Even if this statement is true, it doesn't really help me have confidence in the coding practices of any practice or provider. Checks and balances are necessary. I wouldn't feel comfortable flying with an airline that doesn't require pilots to train and have proficiency evaluations from time to time despite their "years of experience." How will a physician, PA or NP ever know how coding and billing is being conducted if there are no checks and balances.

The Centers for Medicare & Medicaid Services (CMS - can be found at www.cms.hhs.gov) has expectations for healthcare providers. Current law requires that any practice that sees Medicare patients have a compliance plan in place. A required element of any compliance plan is chart auditing with the purpose of identifying and eliminating incorrect (some use the word fraudulent) billing practices.

We've all heard or read horror stories about the FBI confiscating the medical records and/or computer systems of practices, sometimes at gun point. Fraud isn't taken very lightly and it shouldn't be, but sometimes incorrect billing or the simple lack of documentation can lead to disastrous outcomes. Some prevention early on may significantly reduce the risk of such events.

So, why audits? Aside from protection against prosecution for fraudulent billing, there are a number of other excellent reasons to do audits on patient charts. Let me list a few questions or observations that I consider when doing chart audits;

- Is the chart complete - correct forms in the right place, labeled correctly, etc.
- Is the documentation complete, legible and logical
- Is the past medical, family and social history information current
- Are there any missing notes or dictations
- Can the author of any and all notations be easily identified (by name or initials)
- Is the site of service clearly identified (e.g. nursing home, hospital, clinic, etc.)
- Is the date of service or notation clearly documented
- Are all billed items clearly documented in the clinic note
- Does the E/M documentation support the level billed for the given service
- Are current and correct CPT, ICD-9 and HCPCS codes being used
- Are payments being posted correctly
- Are any unpaid or denied claims being investigated

These are only a few items that might be reviewed during a chart audit. It is surprising to me how many of these seemingly simple items are deficient in some patient charts. Chart auditing is so enlightening.

Even with electronic charting, some of these things can get neglected. What I see most often in any charting system is the neglect of the basic history information (HPI, ROS and PMFSHx). The patient's medical history needs to be reviewed and updated often. This should not only include diagnosis past and present, but medications, surgeries, hospitalizations, immunizations, diagnostic studies and so on. Along with that, the family and social history should be documented as well.

As I have explained in previous editions of this newsletter, it does no good to collect information on the first visit and then never update it. During a chart audit, make sure that this information is current. The only way to verify that is if someone has made a notation on the history sheet that the information was reviewed and updated. The date of that review and update and the identity of the person performing that task should be easily identifiable by documentation right on the history sheet or in the electronic record. But that's not all.

When a physician, PA or NP sees the patient and reviews the history information, a simple notation in the encounter note should document that fact. The history information does not need to be duplicated in the encounter note, but documentation of the review of that information by the provider and the person actually reviewing it with the patient is essential. History is one of the three KEY components of evaluation and management (E/M) coding. If

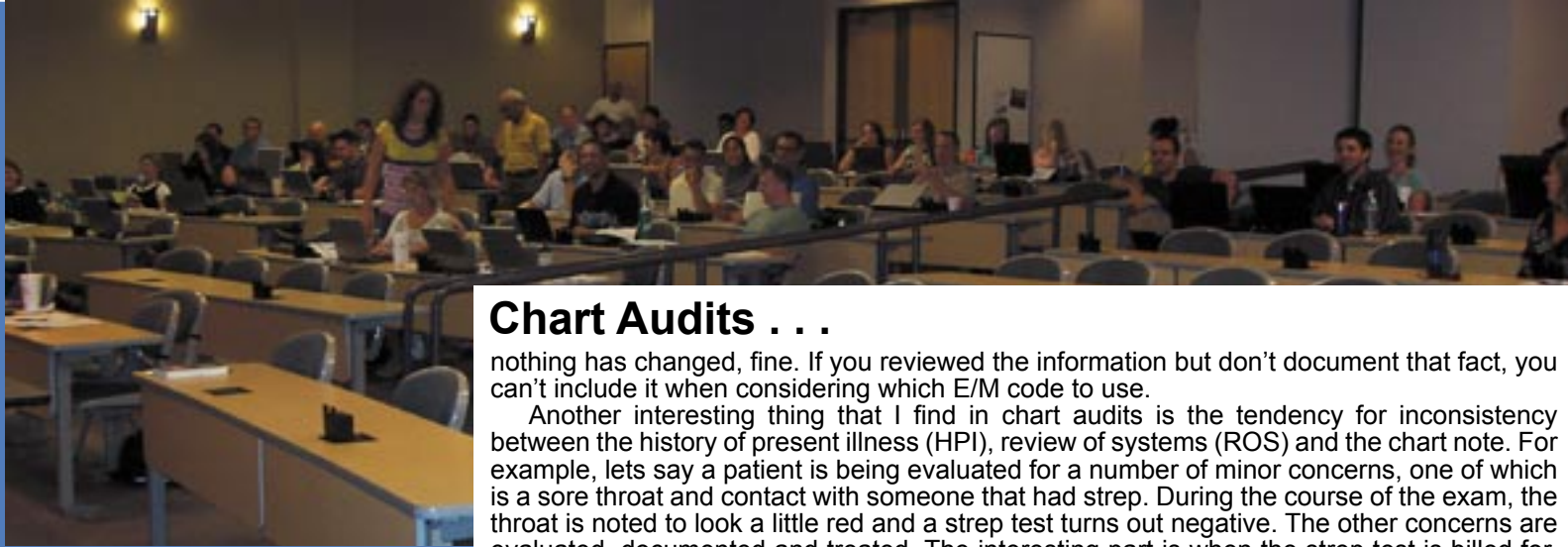


Chart Audits . . .

nothing has changed, fine. If you reviewed the information but don't document that fact, you can't include it when considering which E/M code to use.

Another interesting thing that I find in chart audits is the tendency for inconsistency between the history of present illness (HPI), review of systems (ROS) and the chart note. For example, let's say a patient is being evaluated for a number of minor concerns, one of which is a sore throat and contact with someone that had strep. During the course of the exam, the throat is noted to look a little red and a strep test turns out negative. The other concerns are evaluated, documented and treated. The interesting part is when the strep test is billed for, but no diagnosis of sore throat is included in the final list of assessments.

What I see here is an opportunity for an insurance company to deny payment for the strep test because "sore throat" wasn't one of the diagnosis included on the bill. Sore throat (ICD-9 code 462) should be listed. It may be the fourth diagnosis, but it should be included if you expect to get paid for the strep test. Don't forget that including it also increases the complexity of the patient encounter. You might even want to include the "V" code for exposure to a communicable disease; V01.8.

Consistent auditing will pick up on these problems. Here is how I recommend you initiate chart auditing in your practice. First, everyone participates. Nursing staff, billing staff and all providers (physicians, PAs and NPs). Avoid at all costs the tendency to have the billing department audit the charts and send a report to the providers. Very little learning happens in that situation.

It will be challenging to get everyone together. Some will complain, but it is so worth it that it must be mandatory. Select 5 to 10 random charts for each provider. If you have a pre-printed audit sheet with some of the areas you are concerned about for your audit already outlined, the process will go much easier and the review will be more consistent. Pre-printed audit forms are available from MPECS on the PRODUCTS page at www.mpecs.org.

Attach one audit form to each chart and then use it to audit the most recent encounter note in the chart. It is also very helpful to have a copy of the insurance company's explanation of benefits (EOB) when auditing charts. If you will systematically go through each encounter note looking for the elements of documentation you are most concerned about, you will discover what areas of documentation and coding are deficient and which are not.

Start by looking at the overall organization of charts in your practice. Are they consistent from one chart to another? If you use tabs, are they all there in the correct order? Are they correctly labeled and so on.

Next, look at the most recent encounter note that has been processed by the insurance company. Were all valid charges billed? Were any denied? If so, why? Should you appeal?

Now, look at the encounter note. Is it complete, legible and logical? Is there an adequate HPI? Is the medical history information current or has it been recently updated? Was that information reviewed by the physician, PA or NP at the time of the encounter? How do you know? Is a ROS documented? To what extent?

What kind of exam was performed? Should you use 1995 or 1997 criteria or should you be using single system organ exam criteria? Does the documentation support the level of service billed? How complex is the patient? Is the medical decision making process considered correctly?

What about procedures or tests? Were any performed? Is the documentation adequate? Were they billed? Were they paid correctly?

A practice owner once related to me that he was told by his contracted billing service that they would only bill for charges they were sure they could collect on. Anything else wasn't worth their time. That isn't a billing service I would recommend to anyone.

Once the audit process is completed, everyone now has an opportunity to discuss any problems that have been discovered. This should be an educational experience and no one should feel threatened by it. It will open a level of communication between providers, nursing staff and billing staff that you probably have not experienced before.

Any overbilling or incorrect billing problems should be corrected. If Medicare was billed incorrectly, a check for the overbilled amount should be sent to CMS and claims resubmitted with corrected billing and documentation to explain the reasons for the correction. Self correction goes a long way towards demonstrating willingness to do the right thing and commitment to ethical billing practices. It can't happen if you don't know about it.

Chart audits are highly recommended but rarely undertaken with the correct objective, attitude or perspective. If you have any questions, please let me know. If you need help with audits, I'd be willing to help.

I am offering a new MPECS service; I will audit up to 20 patient encounters and provide a written summary for \$500. Although not as good as an in house audit, it may be a place to start. Audits are essential to the success of any medical practice. Make it happen.



If you are unsure of what constitutes history, exam and medical decision making (you are not alone), you should consider getting a **POCKET CODER** which outlines the specific elements of a patient encounter in an easy to understand matrix format.

Pre-printed chart **auditing forms** are available. And now, you can download an audit form in PDF format for your perpetual use.

See information on the **PRODUCTS** page of this web site.

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